ServiceLink
Aging & Disability Resource Center

Office Use Only
Previously Contacted SL: Yes or No
Saved Work ID:
Password:
Appointment:
Spouse:

MEDICARE PRESCRIPTION
DRUG COVERAGE
PERSONAL INFORMATION WORKSHEET

Name: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Do you receive extra help (Low Income Subsidy): Yes or No

Do you have Medicaid: Yes or No

Birth Date: _____

Medicare ID number: _____

Effective date Part A: _____ Part B: _____

Preferred pharmacy: _____

Address: _____

WHY ARE YOU SEEKING HELP REGARDING MEDICARE PART D? (check all that apply)

- ☐ I am new to Medicare.
- ☐ I have had coverage through insurance, but it is ending: _____.
- ☐ I just became eligible for Medicaid and/or QMB.
- ☐ I am on Medicaid and want to change plans.
- ☐ I just moved to NH from another state: Date of move: _____.
- ☐ I received notice from Social Security that I am eligible for the low income subsidy (LIS).
- ☐ I want to compare plans for the next open enrollment period (October 15th - December 7th).

WHAT TYPE OF PRESCRIPTION COVERAGE DO YOU CURRENTLY HAVE?

- ☐ Medicaid.
- ☐ Prescription drug coverage through an employer or union plan.
- ☐ Prescription drug coverage through a Medicare Part D plan or a Medicare Advantage plan with drug coverage
- ☐ Prescription coverage through the VA
- ☐ None or Unsure

LIST OF PRESCRIPTIONS: (Prescriptions only)

- ☐ **YES**, I can use lower cost generic drugs when available.
- ☐ **NO**, I cannot use generic drugs.
- ☐ Check if you would like **both** Retail Pharmacy (monthly) and Mail Order (3 month supply)

Prescription	Dosage	Daily Amounts

Call Hillsborough County ServiceLink Resource Center if you have a question about this worksheet:

Manchester: **(603) 644-2240**

Nashua: **(603) 598-4709**

Toll Free: **(866) 634-9412**

Please mail this worksheet to:

SERVICELINK RESOURCE CENTER

70 TEMPLE STREET

NASHUA, NH 03060